PCV28

BALANCING EFFICACY AND SAFETY OF PRASUGREL VS. CLOPIDOGREL IN ACUTE CORONARY SYNDROME PATIENTS UNDERGOING PERCUTANEOUS CORONARY INTERVENTION: A POPULATION ANALYSIS OF NET CLINICAL BENEFIT

Schmitt C[1], McCollam PL[2], Creveling TL[2], Oberdiek A[3]
[1]Eli Lilly and Company, Windlesham, Surrey, UK, [2]Eli Lilly and Company, Indianapolis, IN, USA, [3]Daiichi Sankyo Europe GmbH, Munich, Germany

OBJECTIVES: TRITON-TIMI-38 showed reduction in atherothrombotic events with more intensive antiplatelet therapy with prasugrel versus clopidogrel, but with more bleeding. Patients without prior TIA/stroke, patients without any of 3 risk factors for bleeding (prior TIA/stroke, age ≥75 years, weight < 60 kg) and patients with STEMI tended to have greater net clinical benefit. This analysis aims at determining which therapeutic strategy would optimize clinical outcomes in a real-life population with acute coronary syndrome (ACS) undergoing percutaneous coronary intervention (PCI) in Europe. **METHODS:** Published estimates from TRITON-TIMI-38 were used to predict clinical outcomes in a hypothetical population of 10,000 ACS-PCI patients. Strategies analysed were: clopidogrel for all (A), prasugrel for patients without prior TIA/stroke and clopidogrel for others (B), prasugrel for patients without prior TIA/stroke, age <75 years and weight ≥60 kg, clopidogrel for others (C), prasugrel for patients with STEMI, clopidogrel for others (D). Subgroup sizes were derived from the APTOR observational study of 1,525 ACS-PCI patients recruited in Spain, UK and France in 2007. **RESULTS:** Of 10,000 ACS-PCI patients, 9,784 would have no prior TIA/stroke, 7,797 would have none of the bleeding risk factors above, 3,816 would have STEMI. Strategy A would result in 1,205 atherothrombotic events (composite endpoint of cardiovascular death, MI, stroke), 182 major haemorrhage events and 1,385 net clinical outcome events (composite endpoint of all cause death, MI, stroke or major haemorrhage). Alternative strategies would result in incremental events of, respectively, −245, +49 and −196 (B), −211, +39 and −179 (C), −92, +11 and −92 (D). **CONCLUSIONS:** This model suggests prasugrel has a broad place in therapy based on net clinical benefit. Significantly restricted use would prevent disproportionately fewer atherothrombotic events relative to bleeding events. This model may be used to assist health care decision makers, along with other decision-analysis tools, in making recommendations for optimal use of clopidogrel and prasugrel.

PCV29

OUTCOMES ASSESSMENT IN LOW & HIGH RISK P.T.C.A. PATIENTS

Singh S[1], Malhotra S[2], Tiwari P[1]
[1]National Institute of Pharmaceutical Education & Research, Mohali, Punjab, India, [2]Fortis Multispeciality Hospital, Mohali, Punjab, India

OBJECTIVES: The study made an attempt to correlate the costs and health outcomes of the patients who had undergone Percutaneous Transluminal Coronary Angioplasty (PTCA) with stenting. **METHODS:** This retrospective study analysed 258 patients who had undergone PTCA with stenting. Patients were divided into two groups: 1) those with low risk factors (0–2); 2) those with high risk factors (>2). Costs and risk factors were identified. Outcomes like average length of stay (LOS) [average intensive care unit (ICU), non-ICU, post-operative, total LOS)], post surgical survival, post surgical complications, number of readmissions within 1 year for both the groups of patients with low and high risk factors in PTCA were assessed. **RESULTS:** The cost for PTCA [in lakhs ± standard error of mean (SEM)] was higher in the patients with high risk factors (3.23 ± 0.16 lakhs) as compared to the patients with low risk factors (2.75 ± 0.07 lakhs). The patients with high risk factors had a longer LOS (ICU, non-ICU, post-operative and total LOS), slightly lower survival rate, higher incidence of post surgical complications and higher readmission rate within 1 year as compared to the patients with low risk factors. A total of 72 (approx. 30%) patients who underwent PTCA with stenting were readmitted within 1 year. Reasons for readmissions within one year were determined. On readmission, PTCA with stenting were performed in 36% of patients, followed by coronary angiography (33%), medical management (28%), and coronary artery by-pass grafting (3%). **CONCLUSIONS:** High risk patients had a longer length of stay, higher incidence of post surgical complications, poorer survival and higher readmission rate. These results have provided an insight into the costs and outcomes associated with PTCA and will help patients as well as interventionists in decision making regarding allocation of resources for a specific groups or subgroups of patient population.

PCV30

PRACTICE PATTERNS AND QUALITY OF LIFE IN ACUTE CORONARY SYNDROME PATIENTS IN 2008: CZECH REPUBLIC BASELINE RESULTS FROM THE ANTIPLATELET TREATMENT OBSERVATIONAL REGISTRY II (APTOR II)

Coufal Z[1], Norrbacka K[2], Hronkova M[3], Paget MA[4], Sartral M[4], Schmitt C[2]
[1]Bata regional Hospital, Zlin, Czech Republic, [2]Eli Lilly and Company Ltd, Windlesham, Surrey, UK, [3]Eli Lilly and Company Ltd, Vienna, Austria, [4]Eli Lilly and Company Ltd, Suregnes, France

OBJECTIVES: This analysis aims to explore management of acute coronary syndromes (ACS) from acute event to hospital discharge in Czech Republic, and to measure Quality of Life (QoL) at discharge. **METHODS:** This 12-month international prospective, observational study recruited ACS patients undergoing percutaneous coronary intervention (PCI), April–November 2008, capturing practice patterns, resource use and QoL. **RESULTS:** A total of 507 eligible ACS-PCI patients were included: median age 61 (IQR 54–69), median weight 84 (IQR 75–95), 24% female, 23% Type-2 diabetics, and 16% prior myocardial infarction (MI). Index diagnosis was: unstable angina or non-ST-elevation MI (UA/NSTEMI)-43% and ST-elevation MI (STEMI)-57%. Almost all patients (97%) were implanted with stents: 83% bare metal stents (BMS) only, 14% drug eluting stents (DES) only and 3% both. Time from ACS event to PCI was 3 days or less for 80% of UA/NSTEMI patients and 1 day or less for 97% of STEMI patients. Antiplatelet loading oral medications used: aspirin-84% and clopidogrel-98% (no use of ticlopidine). Clopidogrel loading dose (LD) was administered in catheterization lab-26%, previous hospital-22%, ambulance-19%, coronary care unit-19%, emergency room-6%, intensive care unit-3%, and other ward-5% and near PCI (previous 6 hours, during PCI, following 6 hours) in 87% of cases. Total clopidogrel LD was above 300 mg in 56% of cases and in-hospital maintenance dose (MD) was 75 mg in 99%. At time of hospital discharge, 98% of patients were receiving clopidogrel (discharge dose 75 mg in all cases) and QoL was good: median EQ-5D health state index at 1.00 (IQR 0.80–1.00). **CONCLUSIONS:** These real life data reflect treatment patterns among ACS patients managed by PCI in Czech Republic in 2008. Time from ACS to PCI is very low especially in patients with STEMI. During PCI, DES are implanted six times less often than BMS. The QoL of patients at discharge was high.

PCV31

LONGITUDINAL ASSESSMENT OF LIPID ABNORMALITIES IN A SAMPLE OF ITALIAN PATIENTS: PREVALENCE AND ATTAINMENT OF GOAL/NORMAL LEVELS

Ambegaonkar BM[1], Heiman F[2], Soro M[3], Sazonov V[1]
[1]Merck & Co., Inc, Whitehouse Station, NJ, USA, [2]Cegedim Strategic Data, Milan, Italy, [3]MSD Italy, Rome, Italy

OBJECTIVES: The objective of this study was to evaluate attainment of goal/normal lipid levels and predictors thereof following lipid modifying therapy (LMT). **METHODS:** Using CSD LPD database we identified patients age 18+ who initiated LMT between January 1, 2004-October 1, 2006, had a complete lipid profile (LDL-C, HDL-C and TG) 1 year pre and post index date and continued LMT for ≥9 months. High risk population was classified as those with CHD, diabetes or 10-year CHD risk >20%. Guidelines recommended by the current European Society of Cardiology were used to define threshold levels for elevated LDL-C, low HDL-C and elevated TGs. **RESULTS:** Among 524 patients (63% high risk), 93% had elevated LDL-C, 22% had low HDL-C and 62% had elevated TGs before therapy. Additionally, 67% experienced low HDL-C and/or elevated TG irrespective of LDL-C levels. Post therapy (93% on statins), 53% had elevated LDL-C (48% among high risk), 25% had low HDL-C (26% among high risk) and 43% had elevated TGs (39% among high risk). Low HDL-C and/or elevated TG were observed among 54% (52% among high risk). Obesity, presence of diabetes and lower baseline LDL-C were associated with better LDL-C goal attainment while attainment of normal TG level was associated with presence of hypertension and lower baseline TG. Patients with higher baseline HDL-C and older female patients were more likely to attain HDL-C normal level, while female patients with CHD risk >20% were less likely to reach HDL-C normal level. **CONCLUSIONS:** In this longitudinal study of Italian patients, following therapy (where statins were primarily urilized), additional 40% of patients achieved LDL-C goal and additional 19% reached normal triglyceride levels, while no improvement was observed in HDL-C levels where additional 3% had low HDL-C. In addition to baseline lipid levels, certain CV risk factors were strong predictors for goal/normal level attainment of each lipid parameter.

PCV32

A CROSS-SECTIONAL ASSESSMENT OF PREVALENCE OF LIPID DISORDERS AMONG FRENCH PATIENTS IN PRIMARY CARE

Laforest L[1], Ambegaonkar BM[2], Souchet TP[3], Sazonov V[2], Van Ganse E[4]
[1]CHU Lyon, Bron Cedex, France, [2]Merck & Co., Inc, Whitehouse Station, NJ, USA, [3]Merck Sharp & Dohme–Chibret, Paris, France, [4]CHU, Lyon, Bron Cedex, France

OBJECTIVES: This cross-sectional study attempted to identify the extent of prevalence of low high density lipoprotein cholesterol (HDL-C) and/or elevated triglycerides (TG) combined with elevated low density lipoprotein cholesterol (LDL-C) among statin treated patients in French clinical practice. **METHODS:** Using BKL-THALES database we identified patients who were treated with a statin for at least six months and also had a complete lipid profile (LDL-C, HDL-C and TG) within the past six months. Patients were considered to be at high CV risk if they had a history of CV disease, diabetes or 10 year CHD risk ≥20 %. National guidelines in France (AFSSAPS) were used to define lipid threshold levels. Based on these guidelines, HDL-C and TG threshold levels were ≥0.40 g/l and ≤1.5 g/l whereas, LDL-C threshold levels were identified as ≤2.2 g/l, ≤1.9 g/l, ≤1.6 g/l, ≤1.3 g/l or ≤1.0 g/l depending on the number of risk factors and the level of CV risk. **RESULTS:** In a sample of 2544 patients treated with statins (93% as monotherapy), approximately 51% patients (n = 1292) experienced ≥1 lipid abnormalities. Among these, 55% had elevated LDL-C while approximately 25% had elevated LDL-C along with HDL-C and/or TG abnormality. Nearly half (n = 1201) of the sample were high CV risk patients with 71% (n = 854) experiencing ≥1 lipid abnormalities. Among the latter, prevalence of elevated LDL-C was 72%, while nearly one-third experienced low HDL-C and/or elevated TG combined with elevated LDL-C. **CONCLUSIONS:** In this cross-sectional study of French patients treated with statins, over half of all patients (approximately upto three-quarter among high CV risk) with at least one lipid abnormalities experienced elevated LDL-C. In addition, up to one-third of high CV risk patients experienced low HDL-C and/or elevated TG disorders along with elevated LDL-C and could potentially benefit from other lipid-modifying therapies besides statins.